5. Physician Services (Continued)

MAXIMUM MEDICAID PAYMENT RATES FOR PHYSICIAN OBSTETRICAL SERVICES

Procedure Code	Procedure Description	Maximum Payment
	ABORTION	
59812	CPT-4 1997 Code	$420.00
59820	CPT-4 1997 Code	$376.20
59821	CPT-4 1997 Code	$527.60
59830**	CPT-4 1997 Code	$428.26

** Private Insurance has not established a rate for procedure code 59830. It is being manually priced. Arkansas Medicaid's current rate for this procedure code is higher than other states in Region VI, therefore, This rate was not increased.

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SUPERSEDES: TN - 96-10

5. Physician Services (Continued)

MAXIMUM MEDICAID PAYMENT RATES FOR PHYSICIAN OBSTETRICAL SERVICES

Procedure Code	Procedure Description	Maximum Payment
Diagnostic Ultrasound		
	PELVIS	
76805	CPT-4 1997 Code	$132.00 C* $76.00 P* $56.00 T*
76810	CPT-4 1997 Code	$152.00 C* $91.00 P* $64.00 T*
76815	CPT-4 1997 Code	$84.00 C* $58.00 P* $26.00 T*
76816	CPT-4 1997 Code	$84.00 C* $58.00 P* $26.00 T*
76818 **	CPT-4 1997 Code	$86.70 C* $52.02 P* $34.68 T*

• C = Complete Procedure
• P = Professional Component
* T = Technical Component

** The rates for the Complete component for procedure code 76818 was calculated by using the average of the rates for the states in Region VI. We arrived at the Professional rate by using 60% of the Complete component. We arrived at the Technical rate by using 40% of the Complete component.

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SUPERSEDES: TN - 96-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Revised: July 1, 1997

5. Physician Services (Continued)

MAXIMUM MEDICAID PAYMENT RATES FOR PHYSICIAN OBSTETRICAL SERVICES

Procedure Code	Procedure Description	Maximum Payment
Diagnostic Ultrasound (Continued)		
	PELVIS	
76825	CPT-4 1997 Code	$151.80 C* $91.08 P* $60.72 T*
76826	CPT-4 1997 Code	$156.00 C* $95.00 P* $61.00 T*
76827	CPT-4 1997 Code	$143.00 C* $85.00 P* $58.00 T*
76828	CPT-4 1997 Code	$122.00 C* $72.00 P* $49.00 T*
76830	CPT-4 1997 Code	$172.00 C* $104.00 P* $68.00 T*
93975	CPT-4 1997 Code	$220.00 C* $129.00 P* $91.00 T*

* C = Complete Procedure
* P = Professional Component
* T = Technical Component

STATE Arkansas DATE REC'D 5-6-97 DATE APP 7-30-97 DATE EFF 7-1-97 HCFA 179 97-02	A

SUPERSEDES: TN - 96-10

5. Physician Services (Continued)

MAXIMUM MEDICAID PAYMENT RATES FOR PHYSICIAN OBSTETRICAL SERVICES

Procedure Code	Procedure Description	Maximum Payment
Home Medical Services		
	NEW PATIENT	
99341	CPT-4 1997 Code	$52.00
99342	CPT-4 1997 Code	$65.00
99343	CPT-4 1997 Code	$85.00
	ESTABLISHED PATIENT	
99351	CPT-4 1997 Code	$40.00
99352	CPT-4 1997 Code	$53.00
99353	CPT-4 1997 Code	$68.00

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SUPERSEDES: TN - 96-10

5. Physician Services (Continued)

MAXIMUM MEDICAID PAYMENT RATES FOR PHYSICIAN OBSTETRICAL SERVICES

Procedure Code	Procedure Description	Maximum Payment
Office or Other Outpatient Services		
	NEW PATIENT	
99201	CPT-4 1997 Code	$27.00
99202	CPT-4 1997 Code	$41.00
99203	CPT-4 1997 Code	$59.00
99204	CPT-4 1997 Code	$80.00
99205	CPT-4 1997 Code	$125.00
	ESTABLISHED PATIENT	
99211	CPT-4 1997 Code	$13.00
99212	CPT-4 1997 Code	$25.00
99213	CPT-4 1997 Code	$33.00
99214	CPT-4 1997 Code	$64.00
99215	CPT-4 1997 Code	$106.00

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SUPERSEDES: 96-10

5. Physician Services (Continued)

MAXIMUM MEDICAID PAYMENT RATES FOR PHYSICIAN OSTETRICAL SERVICES

Procedure Code	Procedure Description	Maximum Payment
Hospital Inpatient Medical Services - Initial Hospital Care		
	NEW OR ESTABLISHED PATIENT	
99221	CPT-4 1997 Code	$59.00
99222	CPT-4 1997 Code	$84.00
99223	CPT-4 1997 Code	$129.00
Subsequent Hospital Care		
	NEW OR ESTABLISHED PATIENT	
99231	CPT-4 1997 Code	$33.00
99232	CPT-4 1997 Code	$46.00
99233	CPT-4 1997 Code	$62.00
J2790	Rhogam RhoD Immune Globulin	$39.50

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SUPERSEDES: TN - 96-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: July 1, 1994

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6. Medical Care and any other type of remedial care recognized under State Law, furnished by licensed practitioners with the scope of their practice as defined by State Law.

a. Podiatrists' Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed. **The Title XIX (Medicaid) maximum is 66% of the Physician's Blue Shield Fee Schedule dated October 1, 1993.**

At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at a mutually accceptable increase or decrease from the maximum rate. Market forces, such as private insurance rates, medical and general inflation figures, changes in practice costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increase or decrease will be implemented at the beginning of the following State Fiscal Year, July 1, with any appropriate State Plan changes.

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DATE REC'D APR 1 8 1994
DATE APPV'D JUN 2 3 1994
DATE EFF JUL 0 1 1994
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SUPERSEDES: TN - 92-28

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: June 1, 1998

6. Medical Care and any other type of remedial care recognized under State Law, furnished by licensed practitioners with the scope of their practice as defined by State Law.

b. Optometrist's Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum allowed. Effective for claims with dates of services on or after March 1, 1997, the Title XIX (Medicaid) maximum reimbursement for optometrist services is the same as the physician rates for applicable services.

c. Chiropractors' Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed.

Effective for dates of service on or after June 1, 1998, the current Arkansas Medicaid maximum of $23.58 for procedure code A2000 (Manipulation of the Spine by Chiropractor) will be used to establish the reimbursement rate for each CPT procedure code for Chiropractic care. This care will be covered as described in the following procedure codes established by the American Medical Association (AMA) and published in their 1997 Physician's Current Procedural Terminology (CPT) Manual, or such procedure codes as AMA (or it's successor) shall declare are replacements for, and successor' to the following:

98940 Chiropractic manipulative treatment (CMT); spinal, one to two
98941 Chiropractic manipulative treatment (CMT); spinal, three of four regions
98942 Chiropractic manipulative treatment (CMT); spinal, five regions

Effective for dates of service on or after July 1 of each year, Arkansas Medicaid will apply an adjustment factor to the Medicaid maximum. To determine the adjustment factor a comparison between the previous and current year's Medicare rates will be made. The adjustment factor will be equal to the average adjustment made to the Medicare payment rates for all of the above CPT procedure codes as reflected in the current Medicare Physician's Fee Schedule.

d. Other Practitioners' Services

(1) Hearing Aid Dealers - Refer to Attachment 4.19-B, Item 4.b. (10).
(2) Audiologist - Refer to Attachment 4.19-B, Item 4.b. (11).
(3) Optical Labs - Based on contract price. Established through competitive bidding.
(4) Nurse Anesthetists - Reimbursement is based on 80% of the Medicaid Physician Fee Schedule.

SUPERSEDED BY 96-12

TA A
DATE REC'D Amended May 24, 1996
DATE APPV'D August 26, 1996
DATE EFF June 1, 1996
HCFA 179 98-10

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE Revised: July 1, 1994

6.d. Other Practitioner's Services (Continued)

(5) Psychologist Services

Refer to Attachment 4.19-B, Item 4.b. (17).

(6) Obstetric-Gynecologic Nurse Practitioner Services

Reimbursement is the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is based on 80% of the physician fee schedule except EPSDT procedure codes. Medicaid maximum allowables are the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the nurse practitioner and physician.

Refer to Attachment 4.19-B, Item 27, for a list of the nurse practitioner pediatric and obstetrical procedure codes.

7. Home Health Services

a. Intermittent or part-time nursing services furnished by a home health agency or a registered nurse when no home health agency exists in the area;
b. Home health aide services provided by a home health agency; and
d. Physical therapy

Reimbursement on basis of amount billed not to exceed the Title XIX (Medicaid) maximum.

The initial computation (effective July 1, 1994) or the Medicaid maximum for home health reimbursement was calculated using audited 1990 Medicare cost reports for three high volume Medicaid providers, Medical Personnel Pool, Arkansas Home Health, W. M. and the Visiting Nurses Association. For each provider, the cost per visit for each home health service listed above in items 7.a.b. and d. was established by dividing total allowable costs by total visits. This figure was then inflated by the Home Health Market Basket Index in Federal Register #129, Vol. 58 dated July 8, 1993- inflation factors: 1991 - 105.7%, 1992 - 104.1%, 1993 - 104.8%. The inflated cost per visit was then weighted by the total visits per providers' fiscal year (i.e., the visits reported on the 1990 Medicare cost reports) to arrive at a weighted average visit cost.

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SUPERSEDES: TN - 92-32

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
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Revised: October 1, 1994

7. Home Health Services (Continued)
a. b. and d. (Continued)

For registered nurses (RN) and licensed practical nurses (LPN) the Full Time Equivalent Employees (FTEs) listed on cost report worksheet S-1, Part II, were used to allocate nursing costs and units of service (visits). It was necessary to make these allocations because home health agencies are not required by Medicare to separate their registered nurses and licensed practical nurse costs or visits on the annual cost report.

RN and LPN salaries and fringes were separated using an Office of Personnel Management Survey, which indicated that RNs, on an average, are paid 36% more than licensed practical nurses. Conversely, if RNs are paid 36% more than LPNs, then LPNs are paid, on an average, 73.5% of what RNs earn. Cost report salaries and fringes were allocated based on 100% of RN FTEs and 73.5% of LPN FTEs. Other costs and service units (visits) were allocated based on 100% of RN FTEs and 100% of LPN FTEs. RN and LPN unit service (visit) costs were then inflated and weighted as outlined above.

Since home health reimbursement is based on audited costs, the home health rates will be adjusted annually by the Home Health Market Basket Index. This adjustment will occur at the beginning of the State Fiscal Year, July 1. Every third year, the cost per visit will be rebased utilizing the most current audited cost report from the same three providers and using the same formula described above to arrive at a cost per visit inflated through the rebasing year. (The first rebasing will occur in 1996 to be effective July 1, 1997.)

c. **Effective for dates of service on or after October 1, 1994, medical supplies, equipment and appliances for use by patient in their own home - Reimbursement is based on 100% of the Medicare maximum for medical supplies reflected in the 1993 Arkansas Medicare Pricing File not to exceed the Title XIX coverage limitations as specified in Attachment 3.1-A and Attachment 3.1-B, Item 12.c.7.**

STATE Arkansas
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